



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALAN E DELGADO DC
3910 FAIRMONT PARKWAY SUITE H
PASADENA TEXAS 77504

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

CITY OF HOUSTON

Carrier's Austin Representative Box

Box Number 29

MFDR Tracking Number

M4-10-4610-01

MFDR Date Received

July 2, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pre auth not required within the first 2 weeks. Does not require pre auth."

Amount in Dispute: \$3,568.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On several occasions, the provider cites that preauthorization is not necessary for various procedure. This maybe the case if referencing Board Rule 134.600 but as we know with the adoption of the Official Disability Guidelines (ODG) (Board Rule 137.100) any service/procedure that is not recommended, not appropriate or under investigation, a provider must submit a request for preauthorization to the Utilization Review Agent prior to rendering the service for determination. In addition, medical documentation has been requested for several services. We are very willing to review these services for possible payment once any of the requested information is received. Further explanation is listed below based on date of service, procedure code and reason."

Response Submitted by: IMO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 24, 2009 through November 12, 2009	97140, 97032, A4556, 72100, 72050, 72070, 99213, 99354, 97535, 97110, 97750, 98940 and 97012	\$3,568.83	\$801.31

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).

4. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional services rendered on or after March 1, 2008.
5. Former 28 Texas Administrative Code §134.600 sets out the preauthorization guidelines effective March 15, 2004.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- CPT code 99213 rendered on 9/25/09, 9/28/09, 9/30/09, 10/7/09, 10/9/09, 10/12/09, 10/16/09, 10/19/09, 10/21/09, 10/26/09, 10/28/09, 10/30/09, 11/2/09 and 11/4/09 denied by the insurance carrier with denial reason "50 – These are non-covered services because this is not deemed a medical necessity by the payer.
- 197 – Precertification/authorization/notification absent
- INR2 – This service has been disallowed as it is not appropriate treatment in accordance with the Official Disability Guidelines
- NFR – This bill indicates IMO nurse fee review
- 16 – Claim/service lacks information which is needed for adjudication
- 222 – Charge exceeds fee schedule allowance
- W1 – Workers Compensation State Fee Schedule Adjustment
- 962 – Units billed exceeds documented minutes of duration
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 148 – This procedure on this date was previously reviewed
- 18 – Duplicate claim/service
- IMO962 – Units billed exceeds documented minutes of duration. Please submit start and end time for billed units
- 942 – Incomplete billing info or support documentation. Charge will be evaluated upon receipt
- DR – In order to appropriately review the submitted date of service, the report/medical record or office notes are requested
- 4 – The procedure code is inconsistent with the modifier used on a required modifier is missing
- PP – Previously processed for payment
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the disputed CPT code 99213 eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Did the requestor submit documentation to support the billing of modifier -59?
4. Did the requestor obtain preauthorization for the disputed services per former Per 28 Texas Administrative Code §134.600?
5. Did the requestor the requestor submit documentation to support the billing of the disputed charges?
6. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e) (3) (G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation

finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.

2. For the reasons stated above, the requestor has failed to establish that the respondent's payment reason denials concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered for CPT codes 99213 rendered on 9/25/09, 9/28/09, 9/30/09, 10/7/09, 10/9/09, 10/12/09, 10/16/09, 10/19/09, 10/21/09, 10/26/09, 10/28/09, 10/30/09, 11/2/09 and 11/4/09.
3. Per 28 Texas Administrative Code §134.203 (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
 - The CPT Manual defines modifier -59 as follows: Modifier -59: "Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used Modifier -59."
4. Per 28 Texas Administrative Code §134.600 "(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (i) the date of injury..."
 - The injured employee sustained a compensable injury on September 15, 2009. The requestor submitted a copy of a preauthorization letter dated October 5, 2009 issued by IMO Houston, preauthorizing CPT codes 97012, 98940, 97110, 97140 and 97032 to be rendered on October 5, 2009 to November 13, 2009. The preauthorization letter states "IMO has preauthorized medical necessity for 12 Sessions of Initial Lumbar Physical Therapy at 3 times a week for 1 week then 3 times a week for 3 weeks, 4 units per session, with Manipulations x 6 sessions to be done on an Outpatient basis."
 - Disputed Date of Service: September 24, 2009; Disputed CPT Codes: 97140, 97032, A4556, 72100, 72050 and 72070.

Physical or occupational therapy rendered within the first two weeks immediately following the date of injury are not subject to preauthorization.

Review of the CMS 1500 documents that the requestor billed CPT codes 97140, 98940, A4556, 72100, 72050 and 72070.

The requestor did not submit a copy of the CMS-1500 for CPT code 97032. As a result, reimbursement cannot be recommended for CPT code 97032.

CPT Code: 97140: NCCI edits were run to identify edit conflicts. CPT code 97140 has a CCI conflict with Procedure Code 98940, as a result, reimbursement cannot be recommended for CPT code 97140.

CPT Codes: 72100, 72050 and 72070. Review of the submitted documentation does not document that the services rendered under CPT codes 72100, 72050 and 72070, as a result, reimbursement cannot be recommended.

HCPCS Code: A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." The requestor did not submit documentation to support the billing of HCPCS code A4556, as a result, reimbursement cannot be recommended.
 - Disputed Date of Service: September 25, 2009; Disputed CPT Codes: 99213, 99354, 97110 and 97535. Please refer to paragraph 1 and 2 above for dispute decision concerning CPT code 99213.

Review of the CMS 1500 documents that the requestor billed for CPT codes 99213, 99354, 97535.

The requestor did not submit a copy of the CMS-1500 for CPT code 97110. As a result, reimbursement cannot be recommended for CPT code 97110.

CPT code 99354 is defined as "Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)." Review of the documentation submitted does not document the billing of CPT code 99354, as a result reimbursement cannot be recommended for CPT code 99354.

CPT code 97535 is defined as "Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes." The documentation dated September 25, 2009 does not document the billing of CPT code 97535, as a result reimbursement cannot be recommended for CPT code 97535.

- Disputed Date of Service: September 28, 2009; disputed CPT Codes: 99213 and 97110 (2 units). Please refer to paragraph 1 and 2 above for dispute decision concerning CPT code 99213.

Physical or occupational therapy rendered within the first two weeks immediately following the date of injury are not subject to preauthorization. Review of the submitted documentation documents one unit of CPT code 97110 was rendered as billed. As a result, the requestor is entitled to reimbursement in the amount of \$39.93.

- Disputed Date of Service: October 2, 2009; Disputed CPT Code 97750. CPT Code 97750 is defined as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." Review of the submitted documentation dated October 2, 2009 does not document the billing of CPT code 97750, as a result, reimbursement cannot be recommended for disputed CPT code 97750.

- Disputed Date of Service: October 7, 2009; Disputed CPT Codes 99213, 97140, 97032 and 97110. Please refer to paragraph 1 and 2 above for decision concerning CPT code 99213.

Review of the CMS 1500 documents that the requestor billed CPT codes 97140 (one unit), 97032 (one unit) and 97110 (two units) for a total of 4 units on October 7, 2009. Preauthorization was obtained for the disputed charges. Review of the submitted documentation dated October 7, 2009 documents the billing of CPT codes 97140 (one unit), 97032 (one unit) and 97110 (one unit), as a result the requestor is entitled to reimbursement for three of the four units in the amount of \$99.75.

- Disputed Date of Service: October 9, 2009; Disputed CPT Codes 99213, 97140, 97032, 97110, A4556 and 98940. Please refer to paragraph 1 and 2 above for decision concerning CPT code 99213.

Review of the CMS 1500 documents that the requestor billed CPT codes 99213, 97140 (one unit), 97032 (one unit), 98940 (one unit) and 97110 (two units) and A4556. Preauthorization was obtained for the disputed charges. Review of the submitted documentation dated October 9, 2009 documents the billing of CPT codes 97032 (one unit), 98940 (one unit) and 97110 (one unit), as a result the requestor is entitled to reimbursement for three of the four units in the amount of \$104.99

NCCI edits were run to identify edit conflicts. Per NCCI edits, CPT code 97140 has a CCI conflict with Procedure Code 98940. The requestor appended modifier -59 to CPT code 97140, review of the submitted documentation does not meet the documentation requirements for appending modifier -59, as a result, reimbursement cannot be recommended for CPT code 97140-59.

A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." The requestor did not submit documentation to support the billing of HCPCS code A4556, as a result, reimbursement cannot be recommended.

- Disputed Date of Service: October 12, 2009; Disputed CPT Codes 99213, 97032 and A4556. Please refer to paragraph 1 and 2 above for decision concerning CPT code 99213.

Review of the CMS 1500 documents that the requestor billed CPT codes 99213, 97032 (one unit) and A4556. Preauthorization was obtained for CPT code 97032. Review of the submitted documentation dated October 12, 2009 documents the billing of CPT codes 97032 (one unit), as a result the requestor is entitled to reimbursement for one unit of CPT code 97032 in the amount of \$22.95.

A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." The requestor did not submit documentation to support the billing of HCPCS code A4556, as a result, reimbursement cannot be recommended.

- Disputed Date of Service: October 14, 2009; Disputed CPT Codes A4556 and 97032 (one unit).

Review of the CMS 1500 documents that the requestor billed CPT codes 97032 (one unit) and A4556. Preauthorization was obtained for CPT code 97032. Review of the submitted documentation dated October 14, 2009 documents the billing of CPT codes 97032 (one unit), as a result the requestor is entitled to reimbursement for one unit of CPT code 97032 in the amount of \$22.95.

A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." The requestor did not submit documentation to support the billing of HCPCS code A4556, as a result, reimbursement cannot be

recommended.

- Disputed Date of Service: October 16, 2009; Disputed CPT Codes 99213, 98940 and A4556. Please refer to paragraph 1 and 2 above for decision concerning CPT code 99213.
Review of the CMS 1500 documents that the requestor billed CPT codes 99213, 98940 (one unit) and A4556. Preauthorization was obtained for CPT code 98940. Review of the submitted documentation dated October 16, 2009 documents the billing of CPT codes 98940 (one unit), as a result the requestor is entitled to reimbursement for one unit of CPT code 98940 in the amount of \$35.11.
A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." The requestor did not submit documentation to support the billing of HCPCS code A4556, as a result, reimbursement cannot be recommended.
- Disputed Date of Service: October 19, 2009; Disputed CPT Codes 99213, 98940, 97032 and A4556. Please refer to paragraph 1 and 2 above for decision concerning CPT code 99213.
Review of the CMS 1500 documents that the requestor billed CPT codes 99213, 98940 (one unit), 97032 (one unit) and A4556. Preauthorization was obtained for CPT codes 98940 and 97032. Review of the submitted documentation dated October 19, 2009 documents the billing of CPT codes 98940 (one unit), however does not document the billing of CPT code 97032 as a result reimbursement can only be recommended for one unit of CPT code 98940 in the amount of \$35.11.
A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." The requestor did not submit documentation to support the billing of HCPCS code A4556, as a result, reimbursement cannot be recommended.
- Disputed Date of Service: October 21, 2009; Disputed CPT Codes 99213, 98940, 97140, 97012, A4556 and 97110. Please refer to paragraph 1 and 2 above for decision concerning CPT code 99213.
Review of the CMS 1500 documents that the requestor billed CPT codes 99213, 98940 (one unit), 97140 (one unit), 97012 (one unit), 97110 (2 units) and A4556. Preauthorization was obtained for CPT codes 98940, 97140, 97012 and 97110. Review of the submitted documentation dated October 21, 2009 documents the billing of CPT codes 98940 (one unit), 97012 (one unit) and 97110 (one unit), as a result reimbursement is recommended in the amount of \$95.64.
NCCI edits were run to identify edit conflicts. Per NCCI edits, CPT code 97140 has a CCI conflict with Procedure Code 98940. The requestor appended modifier -59 to CPT code 97140, review of the submitted documentation does not meet the documentation requirements for appending modifier -59, as a result, reimbursement cannot be recommended for CPT code 97140-59.
A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." The requestor did not submit documentation to support the billing of HCPCS code A4556, as a result, reimbursement cannot.
- Disputed Date of Service: October 26, 2009; CPT Codes 99213, 98940, 97140, 97012, A4556 and 97110. Please refer to paragraph 1 and 2 above for decision concerning CPT code 99213
Review of the CMS 1500 documents that the requestor billed CPT codes 99213, 98940 (one unit), 97140 (one unit), 97012 (one unit), 97110 (2 units) and A4556. Preauthorization was obtained for CPT codes 98940, 97140, 97012 and 97110. Review of the submitted documentation dated October 26, 2009 documents the billing of CPT codes 98940 (one unit), 97012 (one unit) and 97110 (one unit), as a result reimbursement is recommended in the amount of \$95.64.
NCCI edits were run to identify edit conflicts. Per NCCI edits, CPT code 97140 has a CCI conflict with Procedure Code 98940. The requestor appended modifier -59 to CPT code 97140, review of the submitted documentation does not meet the documentation requirements for appending modifier -59, as a result, reimbursement cannot be recommended for CPT code 97140-59.
A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." The requestor did not submit documentation to support the billing of HCPCS code A4556, as a result, reimbursement cannot
- Disputed Date of Service: October 28, 2009; CPT Codes 99213, 98940, 97140, 97012, A4556 and 97110. Please refer to paragraph 1 and 2 above for decision concerning CPT code 99213.
Review of the CMS 1500 documents that the requestor billed CPT codes 99213, 98940 (one unit), 97140 (one unit), 97012 (one unit), 97110 (2 units) and A4556. Preauthorization was obtained for CPT codes 98940, 97140, 97012 and 97110. Review of the submitted documentation dated October 28, 2009 documents the billing of CPT codes 98940 (one unit), 97012 (one unit) and 97110 (one unit), as a result reimbursement is recommended in the amount of \$95.64.
NCCI edits were run to identify edit conflicts. Per NCCI edits, CPT code 97140 has a CCI conflict with Procedure Code 98940. The requestor appended modifier -59 to CPT code 97140, review of the submitted documentation does not meet the documentation requirements for appending modifier -59, as a result, reimbursement cannot be recommended for CPT code 97140-59.

A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." The requestor did not submit documentation to support the billing of HCPCS code A4556, as a result, reimbursement cannot

- Disputed Date of Service: October 30, 2009; Disputed CPT Code 99213. Please refer to paragraph 1 and 2 above for decision concerning CPT code 99213.
- Disputed Date of Service: November 2, 2009; Disputed CPT Codes 99213, 97140, 97032, A4556 and 97110. Please refer to paragraph 1 and 2 above for decision concerning CPT code 99213.

Review of the CMS 1500 documents that the requestor billed CPT codes 99213, 97140, 97032, A4556 and 97110. Preauthorization was obtained for CPT codes 97140, 97032 and 97110. Review of the submitted documentation dated November 2, 2009 documents the billing of CPT codes 97140 and one unit of 97110, as a result reimbursement is recommended in the amount of \$76.80.

The requestor did not document the billing of CPT code 97032, as a result reimbursement cannot be recommended for CPT code 97032.

A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." The requestor did not submit documentation to support the billing of HCPCS code A4556, as a result, reimbursement cannot

- Disputed Date of Service: November 4, 2009; CPT Codes 99213, 97140, 97032, A4556 and 97110. Please refer to paragraph 1 and 2 above for decision concerning CPT code 99213.

Review of the CMS 1500 documents that the requestor billed CPT codes 99213, 97140, 97032, 97110 and A4556. Preauthorization was obtained for CPT codes 97110, 97140 and 97032. Review of the submitted documentation dated November 4, 2009 documents the billing of CPT codes 97110 (one unit), 97140 (one unit), as a result reimbursement is recommended in the amount of \$76.80.

The requestor did not document the billing of CPT code 97032, as a result reimbursement cannot be recommended for CPT code 97032.

A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." The requestor did not submit documentation to support the billing of HCPCS code A4556, as a result, reimbursement cannot

- Disputed Date of Service: November 12, 2009; CPT Codes 97750 x 2 units and 97750 x 2 units. Functional Capacity Evaluations are billed utilizing modifier FC appending to CPT code 97750. Review of the documentation submitted does not document the billing of a physical performance test. As a result, the requestor is not entitled to reimbursement for CPT codes 97750 x 2 units and 97750 x 2 units.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$801.31.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$801.31 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 19, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.